NASSAU COUNTY SMART SAVINGS PROGRAM
c/o Pamela D'Apuzzo
COMPLETE MANAGEMENT SOLUTIONS, LLC.
55 Kennedy Drive, Suite 2
Hauppauge, New York 11788
(631) 840-5218

NASSAU COUNTY SMART SAVINGS PROGRAM
REIMBURSEMENT FORM

PRIMARY INSURED INFORMATION

PRIMARY INSURED_____
Last Name First Name Middle

PRIMARY INSURED'S ADDRESS_____

_____

Telephone Number_____ Is this a change of Address? Yes____ No___

Insurance Card #_____

PATIENT INFORMATION

1) PATIENT'S NAME_____

PATIENT'S ADDRESS_____
(If different from primary insured's address)

RELATIONSHIP TO PRIMARY INSURED_____ DATE OF BIRTH_____

SEX: M____ F____

PATIENT INFORMATION

2) PATIENT'S NAME_____

PATIENT'S ADDRESS_____
(If different from primary insured's address)

RELATIONSHIP TO PRIMARY INSURED_____ DATE OF BIRTH_____

SEX: M____ F____

*Use a separate sheet for additional patients.

Note: Claimant must provide proof of out-of-pocket expenses totaling $2,000.00 in medical costs that would have otherwise been covered by a second family insurance plan. See reimbursement procedures for more information.

EXPENSES

Patient	Date of Service	Out-of-Pocket Expenses (i.e., co-pays, deductibles)	Reimbursement Amount

* Attach additional sheets if necessary.

The undersigned certifies as follows: To the best of my knowledge and belief, the statements made in this Reimbursement Form are true and complete. These statements are being made for reimbursement of eligible expenses under the Smart Savings Program incurred during the respective plan year for eligible plan participants. I certify that I have exhausted the $2,000.00 buyback amount. I further certify that I have incurred additional expenses exceeding $2,000.00 for expenses that would have otherwise been covered by a second family health insurance plan.

SIGNATURE_____ **DATE**_____

Mail to: **NASSAU COUNTY SMART SAVINGS PROGRAM**
c/o Pamela D'Apuzzo
Complete Management Solutions, LLC.
55 Kennedy Drive, Suite 2
Hauppauge, New York 11788
(631) 840-5218